

# Blue Choice<sup>®</sup> Health Care Plan Application Form

## Instructions:

1. All shaded areas for Ontario Blue Cross use only.
2. Print in ink, or type information.
3. All applicants must complete parts I, II and IV and **sign the application form**.
4. If applying for Hospital Coverage and/or Prescription Drugs options, please complete Parts I, II, III and IV.



<b>You must be a valid OHIP member to apply.</b>		<b>Coverage Applied For</b> (Please ✓) <input type="checkbox"/> Core Health Benefits Only <input type="checkbox"/> Hospital Coverage Only <input type="checkbox"/> Core Health Benefits and Hospital Coverage  <b>Options</b> (Please ✓) <input type="checkbox"/> Prescription Drugs <input type="checkbox"/> Dental	Have you had or do you now have Blue Cross Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please indicate:  Policy ID No. _____ Province _____ Termination Date _____  Group Policyholders Only: <input type="checkbox"/> Conversion Plan Occupation _____
Applicant's Last Name _____ First Name _____			
Address – Street & No. _____ City or Town _____			
Province _____ Postal Code _____			
Applicant's Telephone No. (Home) _____	<b>Marital Status</b> <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other _____		
Applicant's Telephone No. (Business) _____			

### Individual Registration Minimum applicant age is 18 years.

Last Name	First Name and Initial(s)	Sex (M/F)	Birth Date (D/M/Y)	Height (in./cm)	Weight (lb/kg)
Applicant		00	/ /		
Spouse		01	/ /		
Children 1		02	/ /		
2		03	/ /		
3		04	/ /		
4		05	/ /		

Based on your medical history you may be declined or excluded for specific benefits, or given a higher premium.

### Information Statement

For contracts of this type, Ontario Blue Cross anticipates that 75% of the subscriber dues will be required for claims. This is not a contractual obligation. **30 Day Right to Examine Policy:** You have 30 days from the effective date of your policy to examine and return it for refund of monies paid, if you are not entirely satisfied.

### Payment Options \*Send No Money Now\*

#### Choose Mode of Payment

**Credit Card**     MasterCard     Visa     Amex

Credit Card No. \_\_\_\_\_ Expiry Date Month / Year

Annual Payment     Monthly Payment

Cardholder's signature  
**X**

**Monthly Bank Withdrawal** If subscriber dues are to be paid by pre-authorized monthly withdrawals, please complete and sign this section. Please include one of your personal cheques marked "Void"  
I hereby authorize Ontario Blue Cross to draw debits in its favour for payment of my Ontario Blue Cross Coverage. This authorization may be cancelled upon written notice.

Bank Name \_\_\_\_\_ Signature of account holder(s)  
**X**

Bank Address \_\_\_\_\_ (if Joint Account)  
**X**

**Annual Bill** You will receive an annual bill statement that will be sent with your policy.

Part I: Basic Information

**To be completed by all applicants.**

1. Have you or any listed dependents consulted and/or received advice or treatment from a registered specialist or therapist (chiropractor, physiotherapist, psychologist, masseur etc.) during the past two years, or have you been advised to do so?  Yes  No
2. Have you or any listed dependent purchased during the past two years or plan to purchase orthopaedic shoes, supplies or arch supports?  Yes  No
3. Have you or any listed dependent rented/purchased during the past two years or plan to rent/purchase assistive devices (artificial limbs, braces, etc.), medical equipment or supplies (walker, wheelchair, oxygen, CPAP machine, ostomy supplies, etc.)?  Yes  No
4. Have you or any listed dependent required ambulance services or nursing care during the past two years?  Yes  No
5. Have you or any listed dependent consulted a physician or specialist about, been treated for or had any known indication of: heart or circulatory disorder, angina, heart attack, arrhythmia (irregular heartbeat), TIA (mini-stroke) or stroke, insulin dependent diabetes, chronic kidney or liver disease, Chronic Obstructive Pulmonary Disease (COPD) or emphysema, leukaemia or cancer (excluding basal cell carcinoma), Multiple Sclerosis, Motor Neurone Disease, Alzheimer's, Parkinson's, senile dementia or any inheritable disorder (such as polycystic kidney disease or Huntington's chorea)?  Yes  No

If you have answered "yes" to any of the above questions, please provide details below, proceed to next page, and complete Parts III and IV of the application, providing full details. If you have answered "no" to all of the above questions and are not applying for Hospital Coverage and Prescription Drugs options, please proceed directly to Part IV, on the next page. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**For Ontario Blue Cross Use Only**

Identification No.

Underwriting Approval

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**To be completed when applying for Hospital Coverage and Prescription Drugs options, or if any questions in Part II have been answered "yes!"**

**Applicant**

**Spouse**

**1a.** Name and address of personal physician

**2a.** Name and address of personal physician

**1b.** Date last consulted (D/M/Y) \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Reason (if checkup given as reason, what problems/symptoms did you have?)  
\_\_\_\_\_  
\_\_\_\_\_

**2b.** Date last consulted (D/M/Y) \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Reason (if checkup given as reason, what problems/symptoms did you have?)  
\_\_\_\_\_  
\_\_\_\_\_

**1c.** Findings and/or treatment

**2c.** Findings and/or treatment

**3.** Are you or any listed dependent currently taking any prescription medication, have a prescription for which refills are authorized, or have a prescription that has not been filled as of yet?  Yes  No

**If Answer is "Yes", Please Provide Details:**

Person's Name	Prescription Name	Strength	Daily Qty.	Reason	Cost/Presc.	# of Refills/Yr

- 4. Have you or any listed dependent EVER consulted a physician or specialist, been treated for or had any indication of: (Check ✓ yes or no for all questions)**
- |                                                                               |                                                          |                                                                            |                                                          |
|-------------------------------------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------------------------|----------------------------------------------------------|
| <b>A.</b> Heart, circulatory trouble or chest pain                            | <input type="checkbox"/> Yes <input type="checkbox"/> No | <b>H.</b> Stomach, intestinal, liver, kidney or bladder disorder           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <b>B.</b> High blood pressure, stroke, blood disorder or elevated cholesterol | <input type="checkbox"/> Yes <input type="checkbox"/> No | <b>I.</b> Chronic headaches, migraines or recurrent infections             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <b>C.</b> Cancer, tumour or Leukaemia                                         | <input type="checkbox"/> Yes <input type="checkbox"/> No | <b>J.</b> Skin disorder (including acne)                                   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <b>D.</b> Diabetes, Colitis or Crohn's                                        | <input type="checkbox"/> Yes <input type="checkbox"/> No | <b>K.</b> Alcohol or drug dependency                                       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <b>E.</b> Respiratory or Allergy Disorder (including asthma)                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | <b>L.</b> AIDS, ARC (AIDS Related Complex) or other immunological disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <b>F.</b> Bone or joint disorder (including arthritis)                        | <input type="checkbox"/> Yes <input type="checkbox"/> No | <b>M.</b> Infertility/Reproductive disorder                                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <b>G.</b> Mental, nervous or emotional disorder                               | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                                                            |                                                          |
- 5. Have you or any listed dependent been advised, treated or hospitalized for any physical impairment condition, disease or disorder not stated above?**  Yes  No
- 6. Have you or any listed dependent had or currently have a referral, testing, or investigation pending or contemplated but not yet completed?**  Yes  No

**If Answer is "Yes" to 4, 5 or 6, Please Provide Details:**

Quest. No.	Person's Name	Condition	Date First Treated	Date Last Treated	Type of Treatment	Result of Treatment/ Extent of Recovery
			/ /	/ /		
			/ /	/ /		
			/ /	/ /		
			/ /	/ /		
			/ /	/ /		
			/ /	/ /		

Additional Information

- 7.** Have you or any listed dependent smoked tobacco in the last 12 months?  Yes  No If so, who? \_\_\_\_\_
- 8.** Are you or any of your listed dependents pregnant?  Yes  No Due Date \_\_\_\_\_ Who? \_\_\_\_\_
- 9.** Should we require further information to process your application may we phone you during work hours:  
 At home?  Yes  No Most Convenient Time \_\_\_\_\_ At work?  Yes  No Most Convenient Time \_\_\_\_\_

**Maternity benefits for conditions arising due to pregnancy are available only after eight (8) months of continuous coverage.**

In applying for this coverage, I understand that Ontario Blue Cross needs to know the complete medical history of myself and of any family members. I have read over the application and certify that all questions are answered fully and correctly.

I understand and agree that any injury that occurred on or before the date of this application or any sickness which appeared on or before the date of this application must be fully disclosed on this application and may not be covered.

I understand and agree that it is my obligation to inform Ontario Blue Cross of any change in the health of myself and of any family members to be covered due to either injury or illness which occurs after the date of this application and prior to the effective date of the policy.

The discovery of facts known by me or my covered dependents but not disclosed

to Ontario Blue Cross could result in the denial of a claim and the cancellation or modification of the policy.

I agree that this application, any supplemental information as required by Ontario Blue Cross, and the policy shall constitute the entire contract.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, pharmacy, any government health agency or other medically related facility that has any records or knowledge of me or my health or the health of my covered dependents to give Ontario Blue Cross any such information. A photographic copy of this authorization shall be as valid as the original.

I agree that no coverage is in effect unless and until my application is approved by Ontario Blue Cross.

\_\_\_\_\_  
 Dated (Day/Month/Year)

**X** \_\_\_\_\_  
 Signature of Applicant

**X** \_\_\_\_\_  
 Signature of Spouse

**For Agent Use Only**

Agent Name	Agent No.	Tel.	Fax	Agent Signature
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**Mail to: Ontario Blue Cross "Blue Choice"**  
**185 The West Mall, Suite 600**  
**P.O. Box 2000**  
**Etobicoke (Ontario) M9C 5P1**